PSI ADAP Referral Form

To: **PSI State Program Department**. Phone: (866) 392-1309 Fax: **(877) 251-0415**

From: _____ Date: _____ Pages: _____
(referral source name)

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

I (referring entity), _____, have received authorization from _____ (patient name), to disclose his / her medical information and documentation to PSI to serve as a referral for the PSI ADAP program.

Patient Name: _____ **Number of Dependents**: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Patient Phone # (Home): _____ **(Work)**: _____

Date of Birth: _____ **Social Security Number**: _____

Alternate Contact Name: _____ **Phone**: _____

INSURANCE INFORMATION – If available

Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Insurance ID # _____ Group # _____

Annual Out of Pocket: $_____ Deductible: $_____ Co-payment Percentage: $_____

COBRA Policy ☐ YES ☐ NO If COBRA, List Expiration Date: _____

Patient requested PSI send an assistance application: ☐ Yes ☐ No

Please fax completed form to the PSI State Program Department at (877) 251-0415, or mail to the address below.

PSI* PO Box 1602 Midlothian, VA 23113 * Phone (866)392-1309* Fax (877) 251-0415